

282020

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 6 0 5 2
REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Mae Evelyn Ashe | | | 2a. DATE OF DEATH MONTH DAY YEAR September 30, 1985 | | 2b. HOUR M 2:17AM |
| 3. SEX FEMALE | 4. RACE NEGRO | 5. DATE OF BIRTH MONTH DAY YEAR JAN. 31, 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN) MIDDLETOWN, DEL | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD. | | |
| 10. CITY OR TOWN OF DEATH Chestertown | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent and Queen Anne's Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DISABLED | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE MARYLAND | 13b. COUNTY KENT | 13c. CITY OR TOWN MILLINGTON | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE BOX 20 21651 | |
| 14. FATHER'S NAME MIDDLE LAST HENRY ASHE | | 15. MOTHER'S MAIDEN NAME MIDDLE LAST HARRIET TOWNSEND | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNKNOWN) | | 16b. SOCIAL SECURITY NO 221-14-2602 | 17. INFORMANT ADDRESS FLORENCE WILSON sister MILLINGTON, MD 21651 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) ASHE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hrs. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | |
| MEDICAL CERTIFICATION | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from 9/29 , 19 85 , to 9/30 , 19 85 , that (I) (we) lost saw the deceased alive on 9/29 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Wayne D. Benjamin | | DEGREE ATTENDING PHYSICIAN | | 22c. DATE SIGNED 10/1/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wayne D. Benjamin | | 22e. ADDRESS Chestertown, Md 21620 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 10/5/85 | 23c. NAME OF CEMETERY OR CREMATORY DALES CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE MIDDLETOWN, N.C. DEL. |
| 24. FUNERAL DIRECTOR NAME FELLOWS F.H. | | | 25a. DATE REC'D. BY REGISTRAR OCT 8 1985 | | |
| ADDRESS BOX 270 MILLINGTON, MD 21651 | | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | |

030030



COLLON RIBBON
DOWD

TO: [illegible]

FROM: [illegible]

DATE: [illegible]

1951-1-25

WASHINGTON FIELD OFFICE

RE: [illegible]

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8526053

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|--|---|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Marjorie NMN Burris | | | 2a. DATE OF DEATH MONTH DAY YEAR September 27, 1985 | | | 2b. HOUR 9:45A M | | | |
| 3. SEX Female | | 4. RACE Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR Aug 3, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Wilmington, Del. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD. | | | |
| 10. CITY OR TOWN OF DEATH Chestertown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN HOME OR FACILITY, GIVE STREET ADDRESS) The Kent and Queen Anne's Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY home | |
| 13a. STATE Maryland | | | 13b. COUNTY Kent | | 13c. CITY OR TOWN Massey | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST C.W.K. Bradford | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mable Grubb | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | | |
| 16b. SOCIAL SECURITY NO. 221-14-5345 | | | 17. INFORMANT ADDRESS David Nordquist son Wilmington, Del | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia and Septis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <u>ASCD, CHF</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-26</u> , 19 <u>85</u> , to <u>9-27</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>9-27</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Harry Ross MD</u> DEGREE | | | | | | 22c. DATE SIGNED <u>9-28-85</u> | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harry Ross MD | |
| 22e. ADDRESS Washington Ave. Chestertown, MD 21620 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 10/1/85 | | 23c. NAME OF CEMETERY OR CREMATORY Massey Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Massey, Kent, Maryland | | |
| 24. FUNERAL DIRECTOR NAME Fellows F.H. Box 270 Millington, MD 21651 | | | | | | 25a. DATE BY REGISTRAR OCT 2 1985 | | | |
| 25b. REGISTRAR'S SIGNATURE <u>Wenderson-Randall</u> | | | | | | | | | |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or coroner, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

6 5 2 6 0 5 4

REG. NO.

| | | | | | | | | | |
|---|--|--|--|--|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) MILDRED COVEY | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept. 4, 1985 | | | 2b. HOUR 7:15 M | | | |
| 3 SEX female | | 4 RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR March 7, 1911 | | 6 AGE (IN YEARS LAST BIRTHDAY) 74 | | 7. IF UNDER 1 YEAR MONTHS DAYS YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kent Co. Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD. | | | |
| 10 CITY OR TOWN OF DEATH Chestertown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 402 High St. (At Home) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Registrar (Goucher College) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) IN STATE Md. | | 13b. COUNTY Kent | | 13c. CITY OR TOWN Chestertown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 402 High St. 21620 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST A. Howard Covey | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Baker | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 220 30 3760 | | 17 INFORMANT Elizabeth Covey | | 17a. ADDRESS 402 High St. 21620 Chestertown, Md. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) AMYOTROPIC LATERAL SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from 12/84 19, to 9/4 19 85 , that (1) we saw the deceased alive on 8/29 19 85 , and that (2) our opinion death occurred on the date and hour and from the causes stated above, (1) we (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Virginia U. Collier</i> | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/5/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Virginia U. Collier | | | 22e. ADDRESS Chestertown, Md. 21620 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 9/7/85 | | 23c. NAME OF CEMETERY OR CREMATORY Chester Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Chestertown, Md. | | |
| 24. FUNERAL DIRECTOR NAME Willis Wells | | | | | ADDRESS Chestertown, Md. | | 25a. DATE REC'D. BY REGISTRAR SEP 9 1985 | | 25b. REGISTRAR'S SIGNATURE <i>John Gordon</i> |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 6 0 5 5

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Sara Alfonza Hadaway | | | 20. DATE OF DEATH MONTH DAY YEAR August 27, 1985 | | 2b. HOUR 12:44aM |
| 3. SEX female | 4. RACE white | 5. DATE OF BIRTH MONTH DAY YEAR August 21 1903 | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD. | | |
| 10. CITY OR TOWN OF DEATH Chestertown | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker & Board of Education | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Kent 13c. CITY OR TOWN Chestertown | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE Morgnac Village 21620 |
| 14. FATHER'S NAME William R. Haddaway | | | 15. MOTHER'S MAIDEN NAME Emma Gieser | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220 01 9772 | 17. INFORMANT ADDRESS Cannon St. 21620 Thos. Carroll Hadaway Chestertown, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - necrosis of small bowel DUE TO, OR AS A CONSEQUENCE OF (b) - possible - Septicemia DUE TO, OR AS A CONSEQUENCE OF (c) - Asepsis | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Patrick Molony M.D. | | | | 22c. DATE SIGNED 8/27/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patrick Molony M.D. | | | | 22e. ADDRESS Chestertown, Md. 21620 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Aug 30/85 | 23c. NAME OF CEMETERY OR CREMATORY Chestertown Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Chestertown, Md. |
| 24. FUNERAL DIRECTOR NAME Willis Welch | | | | 25a. DATE REC'D. BY REGISTRAR SEP 2 1985 | |
| | | | | 25b. REGISTRAR'S SIGNATURE John Burdett | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

201003

1. Name of the person or organization
2. Address
3. City
4. State
5. Zip
6. Country
7. Telephone
8. Fax
9. E-mail
10. Other



1. Name of the person or organization
2. Address
3. City
4. State
5. Zip
6. Country
7. Telephone
8. Fax
9. E-mail
10. Other

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 6 0 5 6

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) ALICE BACON HEADEN HEADDEN | | | 2a. DATE OF DEATH MONTH DAY YEAR September 23, 1985 | | 2b. HOUR 4:35 P |
| 3. SEX female | 4. RACE white | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 2, 1905 | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD. | | |
| 10. CITY OR TOWN OF DEATH Chestertown | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Magnolia Hall Nursing Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | 13b. COUNTY Queen Anne Centreville | 13c. CITY OR TOWN Rte 1 Box 307 | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Bacon | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Helmig | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218 42 3658 | 17. INFORMANT ADDRESS Rte # 1 Bx 307 Joann W. Valliant Centreville, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident, Right</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Organic Brain Syndrome</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Organic Brain Syndrome</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 1</u> , 19 <u>84</u> , to <u>September 23</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>Sept 9</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Juan K. Ross, M.D.</u> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/24/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JUAN K. ROSS, M.D. | | 22e. ADDRESS Chestertown, Md. 21620 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | 23b. DATE 9/24/85 | 23c. NAME OF CEMETERY OR CREMATORY Silverbrook Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Wilmington, Del. | |
| 24. FUNERAL DIRECTOR NAME J. Willis Wells | | ADDRESS Chestertown, Md. | | 25a. DATE REC'D. BY REGISTRAR OCT 02 1985 | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

377158

YELLOW PAPER



Handwritten text, possibly a signature or date.

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277119

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5

REG. NO. 2 6 0 5 7

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Kathleen W. Kahler | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept. 23, 1985 | | | 2b. HOUR 7:45p M | | | |
| 3. SEX Female | | 4. RACE Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR Apr. 24, 1932 | | 6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ireland | | 7b. CITIZEN OF WHAT COUNTRY? Ireland | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD. | | | |
| 10. CITY OR TOWN OF DEATH Chestertown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anees Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) nurse | | 12b. KIND OF BUSINESS OR INDUSTRY nursing | |
| 13a. STATE Maryland | | 13b. COUNTY Carroll | | 13c. CITY OR TOWN Marydel | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Rt. 1 Box 30 21649 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edward Kavanaugh | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | 16b. SOCIAL SECURITY NO. 221-34-1018 | | 17. INFORMANT ADDRESS Wm. Kahler husband same | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE MICHAEL BEY M.D. | | | | | | DEGREE | | 22c. DATE SIGNED 9/25/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS UNICORN MEDICAL CENTER MILLINGTON, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE 9/28/85 | | 23c. NAME OF CEMETERY OR CREMATORY Silverbrook Crem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Wilmington, N.C. Del. | | |
| 24. FUNERAL DIRECTOR NAME Fedlows F.H. Box 270 Millington, Md 21651 | | | | | | 25a. DATE REC'D. BY REGISTRAR OCT 2 1985 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

1915

280116

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 6 0 5 8

REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ELLEN BACON LINDSEY | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept. 29, 1985 | | 2b. HOUR 1:15 P |
| 3. SEX Female | 4. RACE white | 5. DATE OF BIRTH MONTH DAY YEAR Oct 29 1982 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 102 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD. | | |
| 10. CITY OR TOWN OF DEATH Chestertown | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Magnolia Hall Nursing Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | 13b. COUNTY Cecil | 13c. CITY OR TOWN Hack's Point | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Bacon | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Miller | | 13e. STREET ADDRESS / ZIP CODE P.O. Bx 21919 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 413 74 1306 | | 17. INFORMANT ADDRESS E. Leona Weible Media Pa. 19063 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Approximate Interval Between Onset and Death 10 years | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 15, 1982 to Sept 29, 1985 , that (I) (we) last saw the deceased alive on Sept 25, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Susan Kross, M.D. | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/30/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Susan Ross | | 22e. ADDRESS Chestertown, Md. 21620 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Oct. 2, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Chestertown, Md. | | 23e. LOCATION CITY OR TOWN COUNTY STATE Chestertown, Md. | | | |
| 24. FUNERAL DIRECTOR NAME J. Wilks Wells | | ADDRESS Chestertown, Md. | | 25. PREPARED BY OCT 03 1985 | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows only injury, or other traumatic event, the medical examiner must be notified of same.

BP _____



281073

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 26059

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|--------------------------------------|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. DATE ESTI-MATED | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | |
| HORACE L. LINDSTROM | | Male | | white | | May 29, 1915 | | 70 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| New Jersey | | USA | | WIDOWED | | DIVORCED | | Kent | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Chestertown | | Kent & Queen Anne Hospital | | Excavating Contractor | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Md. | | Kent | | Still Pond | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Box # 21667 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| Frank | | Elizabeth | | no | | 139 05 5124 | | Norma Lindstrom Rowe | |
| | | | | | | | | Columbia, Md. 21046 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | |
| (b) | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | 22a. I certify that I took charge of the remains described above, held on | | | |
| UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | HOUR A.M. MONTH DAY YEAR | | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 | | Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | CITY OR TOWN | | | | | |
| | | | | COUNTY | | | | | |
| | | | | STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | 22b. DATE | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION | | | |
| Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | Oct 1 1985 | | Still Pond Cemetery | | Still Pond, Maryland | | | |
| death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | MEDICAL EXAMINER | | | |
| Robert W. Farr | | M.D. Deputy | | 9/26/85 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | COUNTY | | CITY OR TOWN | | STATE | | | |
| Kent County | | Chestertown, Maryland | | 21620 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Burial | | Oct 1 1985 | | Still Pond Cemetery | | Still Pond, Maryland | | | |
| 24. FUNERAL DIRECTOR | | 24b. DATE REC'D BY REGISTRAR | | 24c. REGISTRAR'S SIGNATURE | | 24d. REGISTRAR'S SIGNATURE | | | |
| NAME | | OCT 7 1985 | | Julia Davidson-Randall | | | | | |
| J. Willis Wells | | | | Chestertown, Md. | | | | | |

2-10-73

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK (100-158888)

RE: MURDER OF MARTIN LUTHER KING, JR.

URGENT 2-10-73 10:00 PM

TO: DIRECTOR, FBI (100-443888)

FROM: SAC, NEW YORK (100-158888)

RE: MURDER OF MARTIN LUTHER KING, JR.

URGENT 2-10-73 10:00 PM

TO: DIRECTOR, FBI (100-443888)

FROM: SAC, NEW YORK (100-158888)

RE: MURDER OF MARTIN LUTHER KING, JR.

URGENT 2-10-73 10:00 PM

TO: DIRECTOR, FBI (100-443888)

FROM: SAC, NEW YORK (100-158888)

RE: MURDER OF MARTIN LUTHER KING, JR.

URGENT 2-10-73 10:00 PM

TO: DIRECTOR, FBI (100-443888)

FROM: SAC, NEW YORK (100-158888)

RE: MURDER OF MARTIN LUTHER KING, JR.

URGENT 2-10-73 10:00 PM



254003

ITEM NUMBER 13, PER. IN. CALI.

STATE OF MARYLAND

1- FOR
STATE
REGISTRAR
16-13-85 D.W.DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 6 0 6 0

REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carolene Elizabeth Miller | | | 2a. DATE OF DEATH MONTH DAY YEAR 9- 2 85 | | | 2b. HOUR 8:15am | | | |
| 3. SEX female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR June 21, 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Kent Co. MD. | | | |
| 10. CITY OR TOWN OF DEATH Chestertown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital Inc. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | | 13b. COUNTY Kent | | 13c. CITY OR TOWN Rock Hall | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET ADDRESS BAYSIDE V. | | | 13f. ZIP CODE 21661 | | | 14. FATHER'S NAME FIRST MIDDLE LAST Charles D. Wood | | | |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Coleman | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | 16b. SOCIAL SECURITY NO. 215 38 1158 | | 17. INFORMANT ADDRESS Nellie V. Pippin Galena, Md. 21635 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable massive myocardial infarct DUE TO, OR AS A CONSEQUENCE OF (b) Heart Longtime Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) ASVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Patrick A. Molony DEGREE MD | | | | | | 22c. DATE SIGNED 9/3/85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patrick A. Molony | | | | | | 22e. ADDRESS Chestertown, Md. 21620 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 9/4/85 | | 23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Rock Hall, Md. | | |
| 24. FUNERAL DIRECTOR NAME Wells Wells ADDRESS Chestertown, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 05 1985 | | 25b. REGISTRAR'S SIGNATURE Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Level 11

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USA

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 6 0 6 1

REG. NO.

1- FOR
STATE
REGISTRAR

281072

| | | | | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|---------------------------------|-----------|---|--|
| 1- DECEASED NAME (TYPE OR PRINT) | | | 2a DATE OF DEATH | | | 2b HOUR | | | | | | |
| FIRST MIDDLE LAST Wilford Henry Payne Sr. | | | MONTH DAY YEAR Sept. 26, 1985 | | | 10:15pM | | | | | | |
| 3. SEX | | 4. RACE | | 5 DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | | |
| Male | | White | | MONTH DAY YEAR Aug. 6, 1893 | | 92 YRS. | | | | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| Maryland | | USA | | | | Kent County MD. | | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | | | | |
| Chestertown | | Kent and Queen Anne's Hospital | | | | Zone Mgr. Int. | | Nat. Harvester | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13d INSIDE CITY LIMITS? | | | 13e STREET ADDRESS / ZIP CODE | | | 12620 | | | |
| 13a STATE Md. | | | 13b COUNTY Kent | | 13c CITY OR TOWN Chestertown | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | Queen St. | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Wilford H. Payne | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sara Ramage | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | | 16b SOCIAL SECURITY NO. WW 1 | | 17 INFORMANT ADDRESS Queen Anne, Md. 21657 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure due to</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>aspiration / gastric contents</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Robert W. Farr</u> | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 8/29/85 | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Farr | | | 22e. ADDRESS Chestertown, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 9/28/85 | | 23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Chestertown, Md. 21620 | | | | | |
| 24. FUNERAL DIRECTOR NAME <u>William Wells</u> | | | ADDRESS Chestertown, Md. | | | 25a. DATE REC'D. BY REGISTRAR OCT 7 1985 | | 25b. REGISTRAR'S SIGNATURE <u>Davidson-Rendell</u> | | | | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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USA

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 6 0 6 2

REG. NO.

| | | | | | | |
|--|--|---|---|---|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) Anna Kirstina M. Pedersen | | | 2a. DATE OF DEATH MONTH DAY YEAR September 13, 1985 | | 2b. HOUR 2:21P M | |
| 3 SEX FEMALE | | 4 RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR AUGUST 14, 1892 | | |
| 6 AGE (IN YEARS, LAST BIRTHDAY) 93 YRS. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9 BIRTHPLACE (STATE OR FOREIGN COUNTRY) DENMARK | | 10 CITY OR TOWN OF DEATH Chestertown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent and Queen Anne's Hospital | | |
| 12a. USHA OF OCCUPATION (TYPE OF WORK, BUSINESS OR VOCATION, IF LIFE) STATISTICAL CLERK | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT. | | 13a. STATE NEW YORK | | |
| 13b. COUNTY SULLIVAN | | 13c. CITY OR TOWN SMALLWOOD | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 13e. STREET ADDRESS / ZIP CODE WEST THOMPSON PLACE 12778 | | 14. FATHER'S NAME FIRST MIDDLE LAST HANS PEDERSEN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KAREN S. LARSEN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 084-12-6092 | | 17 INFORMANT ADDRESS BETHESDA, MARYLAND FRANK PEDERSEN, SON. 9304 KINGSLEY AVE., | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Resp. Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalised Toxemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Perforated Ca Colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 min</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Cardiac Failure</u> | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/11/85</u> , 19 <u>85</u> , to <u>9/13/85</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>9/13</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <u>9-13-85</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SCHREIBER, M.D. | | | | 22e. ADDRESS KENT AND QUEEN ANNE'S HOSPITAL, CHESTERTOWN, MD. | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE 9/15/85 | | 23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA, VIRGINIA | | 24 FUNERAL DIRECTOR RICHARD RAPP, INC. 1804 T ST., N.W., WASHINGTON, D.C. 20009 | | | | |
| 25a. DATE REC'D. BY REGISTRAR SEP 19 1985 | | | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be
 signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3
 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with 72 hours after death
 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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100% COTTON

259018

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) John Ernest Robinson | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 2 85 | | 2b. HOUR 4:30am |
| 3. SEX Male | 4. RACE Negro | 5. DATE OF BIRTH MONTH DAY YEAR May 21 1903 | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD. | | |
| 10. CITY OR TOWN OF DEATH Chestertown | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital Inc. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE MD | 13b. COUNTY Kent | 13c. CITY OR TOWN Worton | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 21678 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Richard Robinson | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Lively | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-16-6158 | 17. INFORMANT ADDRESS Hazel Robinson Worton, MD 21678 | | |

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) PULMONARY EMBOLISM

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0

MEDICAL CERTIFICATION

| | | | |
|--|--|--|---|
| 19a. DATE OF OPERATION 8/29/85 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ACUTE ABDOMEN | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) this hospital attended the deceased from 8/29 19 85, to 9/2 19 85, that (1) we lost saw the deceased alive on 9/2/85 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) we (did) not view the body after death. | | | |
| 22b. SIGNATURE Virginia U. Collier | DEGREE | 22c. DATE SIGNED 9/2/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) VIRGINIA U. COLLIER | 22e. ADDRESS PO BOX 599 CHESTERTOWN MD 21620 | | |

| | | | |
|--|---------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 9/7/85 | 23c. NAME OF CEMETERY OR CREMATORY Morgnec | 23d. LOCATION CITY OR TOWN COUNTY STATE Chestertown Kent Md. |
| 24. FUNERAL DIRECTOR NAME Fellows Funeral Home | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 9 1985 | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the doctor who certifies the cause of death be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the funeral-transit permit. Then please return the completed page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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262059

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 6 0 6 4

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Anna May Schreiber | | | 2a. DATE OF DEATH MONTH DAY YEAR September 7, 1985 | | | 2b. HOUR 2:35P M | | | |
| 3 SEX female | | 4 RACE white | | 5 DATE OF BIRTH MONTH DAY YEAR April 11, 1908 | | 6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Kent County MD. | | | |
| 10 CITY OR TOWN OF DEATH Chestertown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | 13b. COUNTY Kent | | 13c. CITY OR TOWN Chestertown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE High St. (105) 21620 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST James W. Mulford | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Thornley | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 420 34 9877 | | 17 INFORMANT 911 Gen. Geo. Patton Rd. Ann Symonds Nashville, Tenn | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLISM</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>SURGERY FOR CANCER OF COLON</u> | | | | | | | | | |
| 19a DATE OF OPERATION <u>Aug 27 85</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ca COLON</u> | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>26 Aug</u> , 19 <u>85</u> , to <u>7 Sept</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>7 Sept</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>R Schreiber</u> | | | | DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <u>9 Sept 85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Schreiber | | | | 22e. ADDRESS Chestertown, Md. 21620 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL <u>Burial</u> | | 23b. DATE <u>9/9/85</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Silverbrook crematory</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Wilmington, Del.</u> | | | |
| 24. FUNERAL DIRECTOR NAME <u>J Willis Wells</u> | | | | ADDRESS <u>Chestertown, Md.</u> | | 25a. DATE REC'D. BY REGISTRAR <u>9/11/85</u> | | 25b. REGISTRAR'S SIGNATURE <u>John Keenan-Randall</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completed and filed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 6 0 6 5

REG. NO.

1- STATE
REGISTRAR

| | | | | | | | | |
|--|--|---|--|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Calvin Anthony Thomas JR. | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 20 85 | | | 2b. HOUR 12:34 P M | | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR July 4, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD. | | |
| 10. CITY OR TOWN OF DEATH Chestertown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent & Queen Anne's Hospital, Inc. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER | | |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD. | | 13c. COUNTY QUEEN ANNE'S | | 13d. CITY OR TOWN CHURCH HILL | | 13e. STREET ADDRESS / ZIP CODE NEW STREET BOX #106 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST CALVIN A. THOMAS SR. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JOSEPHINE UNK | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW# 217-12-4544 | | 17. INFORMANT NAME ADDRESS MR. ANNA THOMAS BOX #106 CHURCH HILL, MD. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic failure DUE TO, OR AS A CONSEQUENCE OF (b) Probable cirrhosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks years | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Gastrointestinal bleeding | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (the person) attended the deceased from 9/18, 1985, to 9/20, 1985, that (I) (we) last saw the deceased alive on 9/20, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE Wayne D. Benjamin | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/21/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wayne D. Benjamin | | | | 22e. ADDRESS Medical Off. Bldg., Chestertown, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BUR. A1 | | 23b. DATE 9/26/85 | | 23c. NAME OF CEMETERY OR CREMATORY BATEMAN CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE CHURCH HILL QUEEN ANNE'S MD. | | |
| 24. FUNERAL DIRECTOR Name ADDRESS Chestertown Md. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 24 1985 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Pendall | | |

MEDICAL CERTIFICATION

35163